STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 05/09/22 and concluded on 05/11/22.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 residents (Resident #18) observed during administration of eye drops. Failure to ensure nursing staff followed physician orders may result in decreased effectiveness due to the unnecessary use or misuse of an antibiotic. Findings include: Review of the facility's policy titled "Medication Errors" occurred on 05/10/22. This undated policy stated, ". . . The greatest prevention of error is to follow procedures for medication administration as instructed during training." Review of the facility's "Performance Criteria For Medication Administration" occurred on 05/10/22. This undated educational tool stated, ". . . 12. SAFELY administer the correct medication according to the 'Six Rights' . . . the right dose . . . by the right route. . . ."	F 658	The standard of practice was immediately reviewed with the medication aide involved to assure that resident #18 and all other residents' medications are given in accordance with standards of practice which include: right drug, right resident, right dose, right route, right time and properly documented. All other medication aides and nurses were immediately educated via shift report regarding Services Provided Meet Professional Standards. All residents have the potential to be affected. Resident #18 assessed to find no negative outcomes as a result of the failure to follow physician order. A licensed nurse meeting was conducted 5/18/22 by DON addressing the six rights of Medication Administration along with facility standards and policies.	6/13/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 Observation on 05/09/22 at 3:50 p.m. showed a medication aide (MA) (#5) administered one drop of Polytrim (antibiotic) eye drop into both eyes of Resident #18. The prescription label indicated one drop of Polytrim to right eye 4 times daily. Review of Resident #18's medical record occurred on 05/10/22. A medical provider's order, dated 05/07/22, stated, ". . . polymyxin B - 1 drop R [right] eye QID [4 times daily] - conjunctvitis [sic] . . ." During an interview on 05/10/22 at 4:15 p.m., an administrative nurse (#2) agreed the MA failed to follow the medical provider's order.	F 658	A Med Tech meeting was conducted 5/12/22 by DON addressing the six rights of Medication Administration along with facility standards and policies. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/1/22,conducted by charge nurse, DON or ADON. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. The Quality Assurance Director will conduct weekly audits to ensure compliance x4, then monthly under the Pharmacy Quality Assurance checklist labeled "6 rights of medication administration compliance".	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 684	The standard of practice was immediately reviewed with nursing dept	6/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 to provide treatment and care in accordance with professional standards for 2 of 13 sampled residents (Resident #18 and #23). Failure to consistently implement interventions for dressing changes (Resident #18) and skin breakdown (Resident #23) may result in worsening skin conditions or infection. Findings include: - Observation on 05/09/22 at 4:44 p.m. showed two certified nursing assistants (CNAs) (#9 and #12) checked and changed Resident #23 in bed. The resident was incontinent of urine and stool. Observation showed the resident's peri-rectal area was reddened and excoriated. The CNA (#9) stated, "it's pretty red" and applied Lantiseptic (a skin protectant) cream to the area. Observation on 05/10/22 at 9:00 a.m. showed two CNAs (#10 and #11) checked and changed Resident #23 after transferring him to bed. The resident's peri-rectal area remained reddened/excoriated, and a CNA (#11) applied triple antibiotic ointment to the area. Observation on 05/11/22 at 9:02 a.m. showed two CNAs (#8 and #12) checked and changed Resident #23 after transferring him to bed. A nurse (#7) entered the room and gave the CNAs Lantiseptic cream, stating, "I heard his [bottom] was kind of red." The nurse then left the room without observing the area. A CNA (#8) stated to Resident #23, "Your bottom looks sore, I'm going to put some cream on it," and applied Lantiseptic. Review of Resident #23's care plan, CNA Kardex, physician's orders, and treatment	F 684	staff with each shift report regarding quality of care as it applies to all treatments & care provided. The fundamental principle of quality of care/professional standards as it applies to all treatment and care provided was reviewed for all residents with focus on resident #18 & #23 to ensure treatments and cares are provided in a consistent manner according to professional standards of practice. Order and clarification of treatment plan received from hospice regarding specific treatment and care for resident #18. Integrity of dressing documented with each shift by licensed nurse. Care plan updated to reflect changes. Skin integrity and assessment for resident #23 completed and documented. Order and clarification of treatment plan received from MD interventions were consistently implemented. Care plan updated to reflect changes. A licensed nurse meeting was conducted by DON on 5/18/22 addressing the need to provide treatment and care according to professional standards. A med aide meeting was conducted by DON on 5/12/22 addressing the need to provide treatment and care according to professional standards. Starting on 5/12/22 direct care staff were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 administration record failed to identify the reddened/excoriated area and failed to identify interventions to manage the skin breakdown. Review of facility policy titled "Documentation of Wound Treatments" occurred on 05/10/22. This policy, dated 12/04/20, stated, " . . . If no treatment is due, an indication on the status of the dressing shall be documented each shift (i.e., clean, dry, intact,) . . ." - Observation on 05/10/22 at 9:23 a.m. showed a loose, undated, 4x4 gauze dressing on Resident #18's right lower back over a drainage tube catheter. A nurse (#4) pulled the loose gauze over the drain sponge and catheter and secured the dressing with the same tape. The dressing lacked a date. When asked about an order for dressing change the nurse stated, "There is no dressing change order. The dressing is changed with the Pleurx [a tube placed in the chest to remove fluid] drain procedure." Review of Resident #18's medical record occurred on all days of survey. The record lacked a physician's order for a dressing change and documentation for each shift regarding the status of the dressing. During an interview on 05/11/22 at 10:00 a.m. a staff nurse (#3) stated, "The dressing is only changed when the Pleurx drain system is used, and the catheter system kit contains the dressing."	F 684	educated regarding importance of ensuring treatments and cares are provided in a consistent manner according to professional standards of practice. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/1/22 conducted by charge nurse, DON or ADON. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. The Quality Assurance Director will conduct weekly audits to ensure compliance x4, then monthly under the LTC Quality Assurance checklist labeled "Consistently implement interventions for dressing changes and skin breakdown prevention".	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		6/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 4 of 4 residents (Resident #9, #13, #14, and #377) observed being transported in a wheelchair with his/her feet dragging on the floor. Failure to utilize foot pedals on a wheelchair during transport has the potential to result in falls and/or injury. Findings include: Review of the facility policy "Transporting Residents in Wheelchairs" occurred on 05/11/22. This policy, dated February 1995, stated, ". . . To transfer the resident to the wheelchair, the escort should: . . . 4. Adjust footrests and leg supports. . . . During the trip, the escort should: . . . 5. Check the chair frequently to make sure that wheels are free and that the resident's feet are secure on the footrests, (if need footrests). . . ." Observations during survey included the following: * 05/09/22 11:45 a.m. - Staff member (#7) transported Resident #14 by wheelchair from the nurses' station to the dining room without utilizing foot pedals. The resident's feet/slippers made a	F 689	Nursing dept staff education completed promptly with each shift report regarding standard of free of accident/hazards/supervision/devices. Specific education provided regarding residents #9, 13, 14, 377 as well as all residents. Residents immediately assessed and footrests implemented accordingly. Care plans updated as needed. All residents who utilize wheelchairs for transport have the possibility to be affected. Starting on 5/12/22, direct care staff and staff involved with wheelchair transport were educated by DON regarding importance of preventing accidents focusing on wheelchair transport. Policy for Transferring Residents in WC reviewed and updated. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Ransom spot checks will continue daily until 6/1/22 conducted by DON, ADON or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 sliding sound on the floor during transport. * 05/10/22 8:30 a.m. - Staff member (#7) transported Resident #14 by wheelchair from the nurses' station to the dining room without utilizing foot pedals. The resident's feet/slippers made a sliding sound on the floor during transport. * 05/10/22 8:45 a.m. - Staff member (#5) transported Resident #377 by wheelchair from the nurses' station to the resident's room and back to the nurses' station area without utilizing foot pedals. The resident's feet/shoes made a sliding sound on the floor during transport. * 05/10/22 8:49 a.m. - Staff member (#5) transported Resident #9 by wheelchair down the hall to the nurses' station without utilizing foot pedals. The resident's feet/shoes made a sliding sound on the floor during transport. * 05/10/22 11:18 a.m. - Staff member (#5) transported Resident #13 by wheelchair down the hall to the resident's room and back down the hall without utilizing foot pedals. The resident's feet/shoes made a sliding sound on the floor during transport. * 05/10/22 5:15 p.m. - Staff member (#6) transported Resident #14 and Resident #377 by wheelchair down the hall to the dining room without utilizing foot pedals. The residents' slippers/shoes made a sliding sound on the floor during transport. During an interview on 05/11/22 at 2:15 p.m., two administrative staff members (#1 and #2) agreed staff should utilize wheelchair foot pedals while transporting residents when feet are sliding on the floor.	F 689	change nurse. Areas of concern are addressed with individual staff members at time of occurrence with results going to QA committee. Quality Assurance Director will conduct weekly audits to ensure compliance x4, then monthly under Safety Dept QA checklist labeled "Safe wc transport".	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		6/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 6 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure respiratory care consistent with professional standards of practice for 2 of 2 residents observed with portable oxygen (O2) tanks (Resident #23 and #377). Failure to ensure residents receive oxygen as ordered may result in respiratory complications, and failure to transport oxygen in a safe manner may result in accident hazards. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 1292, stated, ". . . Oxygen cylinders need to be handled and stored with caution and strapped securely in wheeled transport devices or stands to prevent possible falls and outlet breakages. . . ." Review of the facility's policy and procedure title "Oxygen Therapy" occurred on 05/11/22. This policy, revised February 2016, stated, "Oxygen is administered to residents who need it, consistent	F 695	Nursing dept staff were educated promptly with each shift report regarding standard of practice for O2 administration and safe handling of O2 tanks to assure that resident # 23 & 377 and all other residents requiring O2 therapy are provided such in accordance with standard of practice. All residents who require O2 therapy have the potential to be affected. Residents #23 & 377 assessed to find no negatives outcomes as result of failure to follow O2 therapy administration orders and safe handling procedures. Care plans updated accordingly. All other residents using O2 therapy assessed to ensure standard is followed. Licensed nurse meeting conducted 5/18/22 by DON addressing the proper administration and safe handling of O2 along with facility standards and policies. A med aide meeting conducted 5/12/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 7 with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. . . . 1. Oxygen is administered under orders of a physician . . . Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy . . . 5. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. . . . 7. Staff shall monitor for complications associated with the use of oxygen and take precautions to prevent them. . . ." - Review of Resident #23's medical record occurred on all days of survey. Current physician's orders included oxygen per nasal cannula at 1-2 liters per minute to keep oxygen saturations above 90%. Observation on 05/10/22 at 5:20 p.m. showed Resident #23 in his wheelchair with an oxygen cylinder delivering oxygen via nasal cannula. The gauge on the cylinder showed the oxygen tank was empty. A medication aide (#5) confirmed the tank as empty. The medication aide brought a new cylinder from the storage closet but failed to secure it in a carrier/cart during transport. After switching the oxygen cylinders, the medication aide carried the used cylinder back to the storage closet and failed to secure it in a carrier/cart. - Observation on 05/10/22 at 8:35 a.m. showed Resident #377 seated in his wheelchair near the nurses' station wearing a nasal cannula and tubing for O2 therapy. A portable oxygen tank located on the back of the wheelchair showed the	F 695	by DON addressing the proper administration and safe handling of O2 along with facility standards and policies. Nursing dept staff were assigned and completed training in Health Care Academy entitled 'Oxygen Use Basics'. Quality Assurance spot checks were implemented immediately for random checks to ensure standard is followed. Random spot checks will continue daily until 6/1/22 conducted by charge nurse, DON or ADON. Areas of concern will be addressed with individual staff members at the time of occurrence with results going to QA committee. The Quality Assurance Director will conduct weekly audits to ensure compliance x4, then monthly under the Safety Quality Assurance checklist labeled "O2 administered as ordered & transported in safe manner".	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355038	A. BUILDING _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GERARD'S COMMUNITY OF CARE	613 1ST AVE SW HANKINSON, ND 58041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 8 oxygen regulator set at 2 liters (L). The tank's regulator arrow pointed to empty. During this time a staff nurse (#4) verified the oxygen tank as empty. Review of Resident #377's medical record occurred on 05/11/22. A Physician Readmission Order Sheet, dated 05/05/22, stated, ". . . DIAGNOSIS: Pneumonia, A-fib [atrial fibrillation], . . . CHF [congestive heart failure] . . . 2L O2 via NC [nasal cannula]. . . ." The current care plan failed to address the resident's use of oxygen. During an interview on 05/11/22 at 11:28 a.m., an administrative nurse (#2) stated staff should transport oxygen in a cart or carrier and check cylinders to ensure they are full.	F 695		